

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-63-015389

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 74

Primary Registration District No. 5295

Registrar's No. 22

STATE FILE NUMBER

**FILED APR 30 1963**

1. PLACE OF DEATH a. COUNTY <b>CLINTON</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Mo.</b> b. COUNTY <b>CLINTON</b>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Plattsburg</b>		Length of stay in 1b <b>7 da's</b>	c. CITY OR TOWN <b>Cameron</b>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Plattsburg Nursing Home</b>		Inside Limits <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	d. STREET ADDRESS (If outside, give location) <b>716 n. 2nd. St.</b>
3. NAME OF DECEASED (Type or print) First <b>Hattie</b> Middle <b>Maud</b> Last <b>Hauger</b>		4. DATE OF DEATH Month <b>April</b> Day <b>16</b> Year <b>1963</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12 1883</b>
9. AGE (last birthday) <b>79 Yr 8</b>		IF UNDER 1 YEAR Months <b>8</b> Days <b>16</b> Hours <b>16</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during previous 12 months, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Housekeeper</b>	
11. BIRTHPLACE (City and state or country) <b>Osborn, Mo.</b>		12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
13a. FATHER'S NAME <b>Ira Barnard</b>		13b. MOTHER'S MAIDEN NAME <b>Lucreta Truex</b>	
14. NAME OF HUSBAND OR WIFE <b>Deceased</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>[REDACTED]</b>		17. INFORMANT <b>Mrs Ruth Moore Cameron Mo.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Kidney Disease</b> DUE TO (b) <b>Memoria</b> DUE TO (c) <b>[REDACTED]</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>2 wks 1 wk.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <b>12:00</b> a.m. <b>12:00</b> p.m.	Month, Day, Year <b>April 9-63</b>	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Plattsburg Mo</b>		20f. CITY, TOWN, OR LOCATION <b>Plattsburg Mo</b>	
21. I attended the deceased from <b>April 9-63</b> to <b>April 16-63</b> and last saw her alive on <b>April 16-63</b> Death occurred at <b>12:00 noon</b> on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE <b>[Signature]</b> (Degree or title) <b>MP</b>	
22b. ADDRESS <b>Plattsburg Mo</b>		22c. DATE SIGNED <b>April 19-63</b>	
23a. BURIAL CREMATION Burial <input checked="" type="checkbox"/> Specify <b>[REDACTED]</b>	23b. DATE <b>Apr. 19, 1963</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Graceland</b>	
23d. LOCATION (City, town, or county) <b>Cameron, MO.</b>		23e. DATE RECD. BY LOCAL REG. <b>Apr-19-1963</b>	
24. FUNERAL DIRECTOR <b>Poland Funeral Home, Cameron Mo.</b>		25. REGISTRAR'S SIGNATURE <b>Mary W Seance</b>	

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

VS 300  
Rev. 4/59  
1 **0250**  
2 **0251**  
3  
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9 **446 X**  
10  
11  
12 **86-0**  
13 **1-0**

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Robert J. Poland*

Licensed Embalmer No.

*4777*

P. O. Address

*222 West 3rd St  
Camden Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.